

Patient Information Form

Patient Number _____ (Office Use Only) 2) Date ____/____/____ Claim Number _____

First Name _____ M.I. ____ Last Name _____ Phone() _____
Street _____ City/Town _____ State _____ Zip Code _____
Age ____ Sex ____ Birth Date ____/____/____ Marital Status (S M W D) Spouse's Name _____
Social Security # _____ Occupation _____ Employer _____
Work Phone () _____ Work Address _____
Person Responsible for this account _____
Would you like to receive occasional E-mail from us? (Y/N) E-mail address: _____

I do not have any Medical Insurance. (signature) _____ Date _____

Insurance Information: (Group ____ Private ____ Work/Comp ____ Automobile ____) Policy# _____
Name of Insured _____ Relationship to Patient _____ S.S# _____
Insurance Co. _____ Group # _____
Street _____ City/ Town _____ Zip Code _____

What is your major complaint? _____ When did this begin? _____

Is this condition due to an: A) Auto Accident B) Work Injury C) Slip & Fall D) Unknown Cause E) Illness

Are the symptoms: A) Improving B) Getting Worse C) About the same D) Come and Go

Have you had these symptoms before? (Y / N) If so, when? _____

Have you seen another doctor for this condition? A) M.D. B) Chiropractor C) Emergency Room D) Acupuncturist

Drs. Name _____ Date Consulted ____/____/____ Diagnosis _____

Drs. Name _____ Date Consulted ____/____/____ Diagnosis _____

Do you or does anyone in your household smoke? (Y / N) _____

Have you had recent weight gain or loss? (Y / N) _____

Have you or any family members been diagnosed with: high blood pressure, diabetes, asthma, tumors, other

Have you ever had any surgery? (Y / N) _____

Please list any medication(s) that you are taking. _____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. **However, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that insurance claims are submitted on my behalf as a courtesy, and it is my responsibility to see that they are paid.** I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest (15%) on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature _____

Date _____

-turn over-

GENERAL SYMPTOMS: (Circle as many as apply)

- A) Nervousness B) Irritability C) Fatigue
- D) Depression E) Loss of Sleep F) Tension
- G) PMS H) Jaw Pain

HEAD: (Circle as many as apply)

- Headache – 1) Mild 2) Moderate 3) Severe
- How often: (1 2 3 4 5 6) Per (Day/ Wk./ Mo.)
- Are they: 1) Sharp 2) Dull
- Are they: 1) Constant 2) Intermittent
- Where located: 1) Back of Head 2) Forehead 3) Temples
- 4) Right Side 5) Left Side 6) Behind Eyes
- B) Light Headed C) Memory Loss D) Fainting
- E) Blurred Vision F) Doubled Vision G) Sensitivity to Light
- H) Loss of Balance I) Hearing Loss J) Ringing in Ears

NECK: (Circle as many as apply)

- Pain--1) Left Side 2)Right Side 3) Both
- Pain Level—1) Mild 2) Moderate 3) Severe
- Type of Pain: Burning / Aching / Dull / Sharp / Stabbing
- Stiffness / Numbness
- Pain increased by: 1) looking down 2) looking up
- 3) turning head left 4) turning head right.
- 5) bending neck left 6) bending neck right
- or with: typing /writing / reading / working /housework
- strenuous activity/driving / sitting / bending /
- lifting / twisting/ standing
- Pain relieved with: Medication /Aspirin /Tylenol /Motrin
- Ice / Heating Pad / Hot Showers / Hot Bath
- Massage / Rest / Stretching

SHOULDERS: (Circle as many as apply)

- A) Pain in Joint---- 1) Left 2) Right 3) Both
- B) Pain Across Shoulder--- 1) Left 2) Right 3) Both
- C) Limitation of Movement-1) Left 2) Right 3) Both
- D) Tension---- 1) Left 2) Right 3) Both

ARMS: (Circle as many as apply)

- A) Pain in Upper Arm---- 1) Left 2) Right 3) Both
- B) Pain in Elbow---- 1) Left 2) Right 3) Both
- C) Pain in Forearm---- 1) Left 2) Right 3) Both
- D) Pins & Needles (Arm)---- 1) Left 2) Right 3) Both
- E) Pins & Needles (Forearm)--- 1) Left 2) Right 3) Both
- F) Numbness in Arm---- 1) Left 2) Right 3) Both
- G) Numbness in Forearm---- 1) Left 2) Right 3) Both

HANDS: (Circle as many as apply)

- A) Pain in Wrist---- 1) Left 2) Right 3) Both
- B) Pain in Hand---- 1) Left 2) Right 3) Both
- C) Pins & Needles (Hand)---- 1) Left 2) Right 3) Both
- D) Numbness (Hand)---- 1) Left 2) Right 3) Both

MIDBACK: (circle as many as apply)

- A) Pain 1) Left 2) Right 3)Both
- Pain Level- 1) Mild 2) Moderate 3) Severe
- Pain Type- Sharp / Stabbing / Dull / Ache
- B) Muscle Spasm 1) Left 2) Right 3) Both

CHEST: (Circle as many as apply)

- A) Chest Pain- 1)Left 2) Right 3) Both
- Pain Level- 1)Mild 2)Moderate 3) Severe
- B) Pain around ribs 1)left 2) Right 3) Both
- Shortness of Breath / Irregular heartbeat

ABDOMINAL SYMPTOMS: (Circle as many as apply)

- A) Pain 1) Mild 2)Moderate 3)Severe
- B) Nervous Stomach C) Nausea D) Gas E) Constipation
- F) Diarrhea G) Heartburn H) Loss of Appetite

LOW BACK (Circle as many as apply)

- Pain--1) Left Side 2)Right Side 3) Both
- Pain Level- 1) Mild 2) Moderate 3) Severe
- Type of Pain: Burning / Aching / Dull / Sharp / Stabbing
- Stiffness / Numbness
- Pain increased by: 1) bending over 2) leaning back
- 3) twisting left 4) twisting right.
- 5) bending left 6) bending right
- or with: strenuous activity / driving / sitting / standing
- walking / lifting / housework
- Pain relieved with: Medication /Aspirin /Tylenol /Motrin
- Ice / Heating Pad / Hot Showers / /Hot Bath
- Massage / Rest / Stretching

HIPS AND LEGS: (Circle as many as apply)

- A) Pain in Buttocks- 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- B) Pain in Hip Joint 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- C) Pain Down Leg- 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- Location- 1) Front 2) Back 3) Side
- Pain radiates to 1) Knee 2) Calf 3) Foot

KNEE:

- A) Pain Level 1)Mild 2)Moderate 3) Severe
- B) Location 1) Left 2) Right 3) Both
- C) Location 1) Front 2) Back 3) Side

FEET: (Circle as many as apply)

- A) Ankle Pain 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- B) Swollen Ankle 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- C) Foot Pain 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- D) Numbness of Feet 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- E) Swollen Feet 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe
- F) Cramps 1) Left 2) Right 3)Both
- Pain Level 1)Mild 2)Moderate 3) Severe

Comments or Other Information:
